SWAMY v. MATTHEWS & ANOR.

[F.C. (Barakbah L.P., Azmi C.J. (Malaya) & Ong Hock Thye F.J.) December 1, 1967]

[K.L. — Federal Court Civil Appeal No. X. 87 of 1966]

Negligence — Professional negligence — Medical practitioner — Standard of care — Administration of acetylarsan — Proper enquiry before administration of — Error of finding of fact by trial judge — Appeal.

This was an appeal against the decision of Ismail Khan J. ([1967] 1 M.L.J. 142) dismissing the appellant's claim against an estate medical officer and his employers for negligence in treatment resulting in paralysis of appellant's arms and legs from polyneuritis.

It was common ground at the appeal that only two injections of acetylarsan, an arsenical compound, were administered. However, the long delay between commencement of the trial and the judgment, due to an abortive interlocutory appeal, had led to an error of fact in the finding of the trial judge, namely, that there had been two heavy doses of 5 c.c. each given without any untoward reactions, before the third and final dose, which was followed shortly after by polyneuritis. Accordingly he held that, the two heavy doses having failed to produce any symptoms of polyneuritis, the third dose was not the cause thereof, nor was the administration of the third dose, in the circumstances, negligent.

Held (Ong Hock Thye F.J. dissenting): the two questions to be decided were: (1) whether polyneuritis was caused by the injection of acetylarsan, (2) if so, was the doctor negligent in giving the injection. Both questions being answered in the negative the appeal must be dismissed.

Per Ong Hock Thye F.J. dissenting: "Had the judge found as a fact that two full doses of 5 c.c. each were administered without untoward effects prior to the last, I have considerable doubts whether he would have come to the conclusion he did."

Rejecting the theory of a latent but dormant ailment as the cause of the polyneuritis, Ong Hock Thye F.J. held that the onus was sufficiently discharged by the appellant in establishing that his polyneuritis was the direct result of the injection. "Diagnosis is of crucial importance in the determination of liability . . . . Was the treatment given here satisfactorily explained? In my judgment it was not, and it was not for the simple reason that, on his own showing, his diagnosis prior to each injection was less than perfunctory".

Cases referred to:—

(1) *Lamphier* v. *Phipos* (1883), 8 Car. & P. 475; 173 E.R. 581.

(2) *Hatcher* v. *Black & Ors.* (1954), *The Times*, June 29, 30, July 1, 2; [1964] C.L.Y. 2289.

(3) *Roe* v. *Minister of Health* [1954] 2 Q.B. 66, 81.

(4) *Bank of Montreal* v. *Dominion Gresham Guarantee & Casualty Co.* [1930] A.C. 659, 666.

FEDERAL COURT.

Dato' S. P. Seenivasagam (*V. C. George* with him) for the appellant.

N. A. Majoribanks for the first respondent.

S. C. Wong for the second respondent.

Cur. Adv. Vult.

Barakbah L.P.: This is an appeal from the judgment of Ismail Khan J. who dismissed the claim of the plaintiff/appellant for damages for negligence against the defendants/respondents.

The appellant suffered disablement while in the employment as an estate conductor of the second respondents after being treated by the first respondent who was a doctor engaged by the second respondents as visiting medical officer to look after the health of their employees. The first respondent treated the appellant for an itch on his hands and legs by injecting a drug called "acetylarsan" which was alleged to have resulted in paralysis of the hands and legs.

On 31st July, 1956, the first respondent prescribed an injection of 5 c.c. of "acetylarsan" which he considered as an adult dose. According to the appellant, after the injection he had a temperature and his face was swollen but Lopez, who was the estate dresser and who gave the injection, stated that the appellant had a slight temperature, a flushed face but not a swelling. On the first respondent's next visit after the first injection Lopez reported to him about the appellant's condition and he examined the appellant. The first respondent diagnosed early pneumonia and ordered that the appellant be removed to hospital. After one week the appellant was discharged and about two or three months later he again complained to the first respondent as on the first occasion. On the second occasion the dose prescribed was half of 1 c.c. and on 23rd November, 1956, Lopez gave the appellant the injection at his house. The appellant then had fever. Lopez informed the first respondent by telephone. He did not come but instructed the appellant be sent to hospital. According to the first respondent, on 23rd November, 1956, the appellant's condition did not warrant sending him to hospital. He was sent there on 27th November, 1956, because of symptom complex. The first respondent also sent a letter by the patient to the medical officer on duty requesting a "full investigation re general debility, chronic nocturnal cough and dermatitis" and adding a note that the patient was sensitive to arsenical drugs. It is just as well to mention here that counsel for both parties agreed that there were only two injections and not three as stated by the learned judge in his judgment.

Now there are two questions which the court has to decide. (1) Was polyneuritis caused by the injection of acetylarsan? (2) If so, was the first respondent negligent in giving such injection? Let us therefore consider the evidence produced in the court below.

According to Lopez (P.W.3), the first respondent diagnosed as a case of psoriasis. He gave the injection of acetylarsan which was prescribed by the first respondent. There was no dispute about the injection. In the evening one of the appellant's children told him that the appellant had a slight temperature. He examined the appellant and found that he had a temperature, a flushed face, not a swelling. He reported to the first respondent about the

appellant's condition on his next visit after the injection. The first respondent examined the appellant with the stethoscope and he instructed that he be removed to hospital. The appellant was discharged from the hospital after about a week. Two or three months later the appellant saw the first respondent again and made same complaints as on the first occasion. The first respondent examined him and recommended acetylarsan of half of 1 c.c., the minimum dose for children. Lopez told the first respondent that after the first injection the appellant had a slight temperature. He further stated that he did not hear the appellant complain anything to the first respondent about the first injection. He gave the appellant the second injection and in the evening the appellant had fever. He informed the first respondent who instructed that the appellant be sent to hospital.

Dr. Khaira (P.W.1) attended to the appellant and in his evidence he stated that the appellant had a peculiar type of disease called polyneuritis and in his opinion this disease could have been caused by allergic manifestation to the arsenical drugs. He further stated that if the appellant had told him that his hand was itchy and said nothing else he would not prescribe acetylarsan. He then went on to say that it was entirely rare to get polyneuritis from arsenical injection. Only cases of polyneuritis from arsenical injection are where large dose of arsenic or successive dose given or if patient is sensitive to any group of arsenic. If there was no serious reaction after first injection one could only tell a patient's sensitivity to injection if a second injection of a minute dose was given. In the present case the first respondent did give the appellant a first injection and as there was no serious reaction he was given a second dose of a very small quantity. Dr. Khaira agreed that it was extremely rare for polyneuritis to be caused by an injection of acetylarsan. Then under cross-examination he contradicted himself by saying that if the appellant came with a complaint of skin disease there was nothing wrong in giving an injection of acetylarsan. In the case of ordinary skin disease he would not give arsenic injection; others might, and according to modern ideas it should not be given.

Dr. Aalders (P.W.2) examined the appellant on 18th March, 1958, that is more than seven months after the commencement of this action and concluded that the appellant had polyneuritis. He said he would not treat a patient with simple skin disease with acetylarsan without looking into his personal history. He was familiar with arsenical injection. It would be usual to give a first dose and a lesser dose if he could carry on with the treatment. He used an interpreter, who was a lawyer's clerk, when he examined the appellant and the symptoms were given through the interpreter and they appeared to have been taken from the book kept by the doctor. P.W.2 was not prepared to say what the cause of the polyneuritis was.

Professor Ransome (D.W.1), a professor in the University of Malaya, gave evidence that he had experience of arsenic compound injection during the war and that he knew of "no case of anyone suffering from polyneuritis due to injection or oral administration". He stated acetylarsan could be prescribed for skin diseases of hand and in case of acetylarsan reaction, if any, would be very mild. No harm would be caused by giving a second injection two months after the first injection. He went on to say that it was possible that polyneuritis had nothing to do with acetylarsan. One could not say the exact cause of it. He further stated: "From what I have seen of plaintiff's hands, and when he says it is itchy, I say it is scaly dermatitis and it is one of the things for which arsenic could be prescribed". Dr. Khaira also held the view that if the appellant came with a complaint of skin disease there was nothing wrong in giving an injection of acetylarsan.

The first respondent in his evidence stated that he had vast experience in arsenical injections both before and during the war and had experience in the use of acetylarsan for 20 years. He used to give 5 c.c. dose without any trouble at all. He did not consider himself wrong when he did not follow the specific instructions in Exhibit D.8. He was prepared to depart from the recommended dose of 3 c.c. He would have exceeded the maker's prescription but he could still consider it a safe dose. He went on to say: "One must look at the personal history of patient, but I found plaintiff was estate worker and must have been in contact with arsenic. I give injection of acetylarsan as there was no harm in it. . . . . I say from my personal experience acetylarsan has not caused polyneuritis".

Now on the law. A man or a woman who practises a profession is bound to exercise the care and skill of an ordinary competent practitioner in that profession — be it the profession of an accountant, a banker, a doctor, a solicitor or otherwise. In the case of *Lanphier* v. *Phipos* [1] Tindal C.J. laid down this principle:—

> "Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest degree of skill. There may be persons who have higher education and greater advantages than he has; but he undertakes to bring a fair, reasonable and competent degree of skill."

Again in the case of *Hatcher* v. *Black & Ors.* [2] Denning L.J. (as he then was) said that, in a hospital when a person was ill and came in for treatment, no matter what care was used there was always a risk; and it would be wrong and

bad law to say that simply because a mishap occurred the hospital and doctors were liable. Indeed, it would be disastrous to the community. It would mean that a doctor examining a patient or a surgeon operating at the table, instead of getting on with his work, would be for ever looking over his shoulders to see if someone was coming up with a dagger; for an action for negligence against a doctor was like unto a dagger; his professional reputation was as dear to him as his body — perhaps more so. And an action for negligence could wound his reputation as severely as a dagger could his body. The jury must therefore not find him negligent simply because one of the risks inherent in an operation actually took place, or because in a matter of opinion he made an error of judgment. They should find him guilty when he had fallen short of the standard of reasonable medical care, when he was deserving of censure.

Having regard to the evidence of the three medical witnesses and that of the first respondent, with respect, I agree with the learned judge that the polyneuritis was not caused by the injection of acetylarsan and that the first respondent was not negligent in giving the injection. In my view the learned judge had arrived at the right conclusion and in the circumstances I would dismiss the appeal with costs.

Azmi C.J. (Malaya): I have had the opportunity of reading the judgment of the Lord President and I agree that the appeal be dismissed with costs.

Ong Hock Thye F.J.: The appellant suffered paralysis of his hands and legs after the second of two injections of an organic compound of arsenic known as "acetylarsan." This was the treatment prescribed by the first respondent, a visiting medical officer retained by the second respondent to look after the health of their employees. The appellant's claim for damages on the ground of negligence having been dismissed by Ismail Khan J., he now appeals to this court against such decision.

Until his disablement the appellant had been an estate conductor for several years. He entered the second respondent's employment in April 1956. On July 31, 1956 he went to see the first respondent about an itch on two fingers of his right hand. What happened then, relating to the diagnosis, undoubtedly is of crucial importance in determining the question of liability. I shall, therefore, quote the doctor's diagnosis in full:—

"He had early skin rashes circular in nature which might be a ringworm infection or early psoriasis. He had scaly dermatitis. I proposed to treat him for early psoriasis. I did not treat him for dermatitis as it looked too permanent. As to psoriasis it was not a complete final diagnosis. The term used is differential diagnosis. That means a short list of two or more diseases which can only be decided by further observation and treatment. Plaintiff was estate clerk. In this respect *any estate worker can be subject to an allergy* and allergic forms vary in proportion of all skin diseases. It might be great or neglible. *To see if a person on estate is allergic to a particular drug, you can give test doses and observe its effect.* Psoriasis is reasonably common on estate. It is not serious but will cripple a person. In this case the next step would be to give a medicine which would cure one and not the other — ringworm or psoriasis. I used acetylarsan, I had used it in thousands of cases. I recommended one ampoule for plaintiff. It means 5 c.c. It is a normal dose for adults. I could have prescribed more in a major case. 5 c.c. is average adult dose. I expected reaction after injection. Reactions vary in degree. 30% of injections are followed by rising temperature of some sort."

Later on the same day the injection was given by Lopez, the estate clerk-cum-dresser, to the appellant at his house; the doctor who was not present, had, of course, no opportunity of observing the reaction, if any. He visited the estate only on Tuesdays and Fridays and, according to Lopez, was subsequently informed on his next visit of the appellant's developing a slight temperature.

At this stage I think I ought to digress for a moment to clear up one point on which, unfortunately, the learned judge appears to have fallen into error. This was doubtless due to the long interval that elapsed between the commencement and the close of the trial; between those dates there had been an abortive interlocutory appeal. The judge has found that three injections were administered, a full dose on July 31, a second similar dose on September 21 and a third small dose on November 27. Counsel on both sides, however, inform us it was common ground that only two injections were in fact given — the only matter in difference being the date of the first injection. Having examined the evidence on the record and formed my own conclusions thereon the only fact that mattered is that the appellant was given a first injection of 5 c.c. The date it was given is of no significance.

What actually happened on September 21 was that, on the doctor's orders, the appellant was sent to Seremban General Hospital for suspected pneumonia and was discharged after three days. It was the appellant's contention — that the very first injection required his admission into hospital for observation — which had led to the confusion. The events of September, however, were of incidental relevance only in one respect. Had the judge not found as a fact that two full doses of 5 c.c. each were administered without untoward effects prior to the last, I have considerable doubts whether he would have come to the conclusion he did.

On November 27, the appellant saw the doctor again. He still had the itch on his fingers. Acetylarsan was prescribed, again without any sort of inquiry into his history. Lopez gave the injection. Four days later the doctor ordered the appellant's hospitalisation, with a

written message to the medical officer in charge, requesting "a full investigation re general debility, chronic nocturnal cough and dermatitis" and adding, in parenthesis, that the patient "is sensitive to arsenical drugs". No beds being immediately available the appellant was not admitted until December 3. He was discharged on January 30, 1957 and the medical certificate issued to him by Dr. Khaira, consulting physician at the hospital, gave his diagnosis as "polyneuritis? Arsenical."

To the second respondent, his employers, Dr. Khaira wrote on February 8, 1957 as follows:—

"Mr. T. T. Swamy is suffering from a polyneuritis which could have been caused by administration of arsenic. He gave a history that he was given arsenic injections and also that he supervised spraying of weed killer.

It appears he is quite sensitive to arsenic and therefore I believe that his illness is due to this cause. It is very unlikely that he will be able to regain his normal health."

On February 5, 1957 the first respondent made his clinical report by letter to the respondent-company's manager, as a result of which the appellant was dismissed. The report was as follows:—

"I have given this case a very thorough clinical overhaul, and have thought over what to say about him long and carefully.

On his own admission he was discharged from hospital with a vague negative set of findings; one thing he certainly has not got is arsenical poisoning; no arcenic was found in his excreta and he was not given arsenic antidotes; which disposes of that problem.

On the other hand, I find it most difficult to decide finally on his ultimate diagnosis. The clinical picture he presents runs parallel with no regular set of symptoms. His findings are all negative or in the regions of normality.

The most striking feature is a series of cramping contortions which occur from time to time. This is often seen in genuine tetany, and for a time I thought that might be the possible diagnosis. However I tried his electrical reflexes, and obtained the same series of movements when one terminal was not touching him, or both terminals were touching but the current switched off. He is of course obviously ill, and had to be carried into my consulting room, but once there, had no great difficulty in adjusting his movements to the needs of my examination.

I am unaware of his domestic background, but to my mind he presents three alternatives two common and one unusual though it cannot be ruled out.

He is a very good picture of a case which seeks illness subconsciously as an escape from domestic or business worry; the term is 'psychosomatic', and without doubt there is a very large element of this in the picture. If it has not already been made, I would suggest enquiry into his affairs to support or refute this idea.

One of the accompaniments of a psychosomatic case is loss of appetite and this starts up a vicious circle of malnutrition which increases the patient's distress till he becomes really ill. Once malnutrition sets in, of course, any chain of physical signs can develop, nervous signs being common, even to the degree of complete paralysis of a part or all of the body; even in extreme cases, to permanent invalidism and death.

The second possibility is derived from the first; that is tetany, which has a complicated origin linked with calcium deficiency and glandular changes.

The third, given with all seriousness, is that from some source or other he is receiving drugs, poisons, charms. (To me) having lived many years in West Africa, he presents a lively picture of what in those days we vulgarly used to call 'juju'.

I regret I can be of no further assistance; my own personal view is that he is an admixture of the first two causes. He is, of course, no further use to your company, and I can find not the slightest sign to indicate that your company can be held legally or morally responsible for his illness.

Should you care to take this up with another medical opinion, the figures obtained from his examination are available, and I have no objection to a copy of this letter being supplied also."

Turning now to the judgment, the learned trial judge dealt with the issues thus: (1) Was polyneuritis caused by the injection or injections of acetylarsan? (2) If so, was the doctor negligent in prescribing such treatment? Then he went on:—

"As to the first question, it is true that polyneuritis developed within a few days after the relevant injection. But was the one so related to the other as to be unmistakably in the nature of cause and effect? Is the mere coincidence in point of time sufficient to establish that the acetylarsan, *and the acetylarsan alone*, could have caused the polyneuritis? By itself, and without any other relevant evidence to the contrary, it should be rightly said that the onus on the plaintiff has been satisfactorily discharged by proof of the injection and the disablement that followed." (The italics are mine).

In the judge's opinion, however:—

"Two previous injections of 5 c.c. did not produce any symptoms of polyneuritis, whereas the third dosage, to which polyneuritis is attributed, was the reduced one normally given to a child, which would be comparatively much less effective. It seems to me strange that if two potent doses did not cause polyneuritis, a mild one on the third occasion should have that effect. Accordingly, it seems to me more logical and reasonable to hold that the itching sensation which the plaintiff felt shortly after he took up employment with the second defendant might be symptoms of an impending ailment which was already latent, but dormant, in the plaintiff's system, rather than a superficial skin disease brought about by improper diet."

After reviewing the evidence given by Dr. Khaira, Dr. Aalders and Professor Ransome (of which the last-named was a witness called for the defence) the judge came to the following conclusion:—

"In view of the evidence of the three medical witnesses, not to mention the fact that two earlier injections failed to bring about polyneuritis, I have come to the conclusion that the plaintiff has not discharged the onus, even on a balance of probabilities, that the injection of acetylarsan was the cause of his polyneuritis."

Having so found for the defendants on the first issue, the judge went on to consider the independent medical evidence with regard to the question of negligence. His conclusion was:—

"I find that the absence of any untoward reactions to the first and second injections of a full dose did not impose on the first defendant any duty to take extra-

ordinary care before repeating a third and smaller dose — in fact, the reduction in the third dosage was evidence of caution."

I have thought it necessary to quote in the foregoing pages, not only the respondent doctor's evidence in full regarding his first diagnosis, but also his subsequent clinical report and lengthy excerpts from the judgment of the learned trial judge. The reason, as I have explained earlier, is that diagnosis is of crucial importance in the determination of liability. In my judgment the decision of this case must turn on it. Diagnosis is the identification of a disease by means of its symptoms. It is apodeictic that the disease or diseases affecting a patient should be identifiable before the nature of the treatment therefor can properly be considered. Where the symptoms do not enable a clear diagnosis to be made, it seems commonsense that the doctor ought to proceed with his treatment on a tentative basis; certainly not on the assumption of a positive identification of the disease *and its cause*. Therefore, in my judgment, failure on the part of a physician to exercise proper care in diagnosis is a failure to stand up to the test of skill required of the ordinary skilled man exercising and professing to have his special skill. The close interrelation between diagnosis and treatment admits of no argument. Hence, it seems to me that the nature of the treatment given affords a fairly reliable test of the degree of care taken in the diagnosis itself.

In this case the appellant had just been employed on the estate; hence, the doctor could not have been remotely familiar with his case history. Of him the doctor only knew this much:—

"Field workers come at some time or other in contact with arsenic and would show it . . . . *I guessed* plaintiff must have come in contact with arsenic . . . . One must look at the personal history of patient, but I found plaintiff was estate worker and *must have been in* contact with arsenic. . . ."

Pausing here for a moment, it seems to me that, when the skin condition and contact with arsenic plainly suggested sensitiveness to this drug, a test dose, and no more, should have been given, if at all arsenic was to be used. With regard to the first diagnosis, it will be recalled that the doctor said: "In this respect any estate worker can be subject to an allergy and allergic forms vary in proportion of all skin diseases. It might be great or negligible. *To see if a person on estate is allergic to a particular drug, you can give test dose and observe its effect.*" I think it is fair to say that the 5 c.c. given for the first time was not a test dose. May & Baker Ltd., the manufacturers of acetylarsan, state that "The average individual dose for adults is 3 c.c. although *it is customary to test tolerance by giving a first dose of 1 c.c.*" (see Ex. D8). In view of this, I should have thought that, against a recommended test dose of 1 c.c., or even an average dose of 3 c.c., the dose of 5 c.c. can fairly be described as massive. I observe that, in their letter of September 23, 1957 (Ex. D7) to the doctor's solicitors, May & Baker Ltd. had this to say:—

"Firstly, on the assumption that 'acetylarsan' was properly indicated for your client's patient, we are inclined to the view that the rise in temperature and swelling of the feet and body which apparently occurred after the injection must have been of such a degree that your client *should have seriously considered whether or not it was advisable to continue treatment with acetylarsan or indeed any other arsenical preparation.* You have confirmed that your client was aware of the *warning in the direction slip which is enclosed with each box of 'acetylarsan' ampoules, that a patient's tolerance should be tested by giving an initial small dose.* However, the fact that a second injection of a smaller quantity of 'acetylarsan' was given some two months later must, we assume, mean that your client, who you state has much experience of the use of arsenicals, was reasonably satisfied that further administration of 'acetylarsan' was justified.

xxx xxx xxx

The inherent risks of arsenic therapy, and the precautions to be observed to minimise them are well-known. We do not think that any organic compound of arsenic used in clinical practice can be claimed to be entirely free from toxicity, but having searched the medical literature we have failed to trace any published report of the occurrence of polyneuritis due to the use of 'acetylarsan', nor have any such instances been reported to us privately." (The italics are mine).

As to the final dose given on November 27, the doctor himself said:—

"*After a long lapse of time there is no predicting what effect of second injection would be.* Whether (or not) Lopez said he had fever I would still give reduced dosage. I cannot remember if I examined plaintiff's body, apart from his hands. I sent plaintiff to hospital in November after injection for general debility and depression. I thought this could be treated in the hospital. Treatment depends on causation."

In view of the above, even had the first dose brought on nothing more serious than a fever, can it be said that the second dose was given after any, or any careful, diagnosis? The doctor could not recall if he had made any examination, other than of the patient's hands, before prescribing acetylarsan for the second time. Moreover, he had made no personal observation of the patient's reaction at any time after the first dose. The patient had come back for further treatment, which showed that even the first massive dose could not have proved effective. Could there have been any justification then for the second dose? As a layman I would not venture to give an answer, although I observe that neither Dr. Khaira, nor Dr. Aalders, nor Professor Ransome, had been asked whether they would themselves have *repeated* the injection of acetylarsan. However, I think I am at least competent enough to express a layman's opinion on another point. I have, a little earlier, just quoted the doctor having said: "I sent the plaintiff to hospital in November *after injection for general debility and depression.*" I think I am not wrong in believing that in 1956 no injection of arsenic would

ever have been prescribed by any general practitioner for treatment of depression.

The learned trial judge himself has quite rightly pointed out that "polyneuritis developed within a few days after the injection." *Prima facie* a nexus was thus established between them. "But", he asked, "was the one so related to the other as to be unmistakably in the nature or cause and effect? Is the mere coincidence in point of time sufficient to establish that the acetylarsan, *and the acetylarsan alone,* could have caused the polyneuritis?"

With respect, I think that this view laid an unduly heavy onus on the appellant. Assuming that he was in a low state of health, and in such state likely to fall victim to polyneuritis by reason of its being triggered off by the second dose, can it not be said that this injection was the direct cause? Bad health and reduced bodily resistance might have been contributory factors: nevertheless, it was the injection or injections which brought on the attack of polyneuritis. Or, supposing the appellant had developed sensitiveness to arsenic? This, I believe, can happen to any person at any time in respect of some particular drug, notwithstanding previous tolerance shown towards the same drug. In that event, was not an injection of even a very small dose sufficient to produce serious consequences?

I turn now to the trial judge's view of the probable alternative cause. He had clearly been much impressed by the apparent tolerance shown in respect of two earlier doses, although in fact there was only one. It was for this reason that he thought the real seat of the trouble was to be found in the itching sensation "which might be symptoms of an impending ailment, which was already latent but dormant, in the plaintiff's system." With respect, I believe that sensitiveness can suddenly develop without warning, in spite of past tolerance, as is well-known, for instance, in relation to penicillin. Such sensitiveness, in fact, was unmistakable after the last injection. How else is one to view the warning in the doctor's note addressed to the medical officer at the Seremban hospital about the appellant's "sensitiveness to arsenical drugs"? Consequently, a mistake of fact having been shown, I feel less diffident in disagreeing with a judge for whom I have the highest respect. In my judgment his theory of a latent, but dormant, ailment finds no support from the evidence of any of the medical witnesses. Only one feeble attempt at explanation was given; it may be found in the clinical report of the respondent doctor himself, which I have already quoted in full. The learned trial judge did not even consider it worth commenting upon and I entirely agree. Much, if not all, of it was wild surmise, unsupported by a scrap of evidence. On the other hand, in *Price's Textbook of the Practice of Medicine* (*edited by Donald Hunter*) I find it clearly stated that "peripheral neuritis may be caused by a single large dose of arsenic." (Polyneuritis is the synonym for multiple peripheral neuritis).

For the reasons which I have stated above I have little hesitation in holding that the onus was sufficiently discharged by the appellant in establishing that his polyneuritis was the direct result of the injections of acetylarsan. Was the treatment, in the circumstances, attributable to negligence on the part of the doctor? In *Roe* v. *Minister of Health,*[3] Denning L.J. (as he then was) said of the plaintiffs:—

> "Each of them was given a spinal anaesthetic by a visiting anaesthetist, Dr. Graham. Each of them has been paralysed from the waist down. The judge has said that those facts do not speak for themselves, but I think that they do. They certainly call for an explanation. Each of these men is entitled to say to the hospital: 'While I was in your hands something has been done to me which has wrecked my life. Please explain how it came to pass'."

Was the treatment given here satisfactorily explained? In my judgment it was not; and it was not for the simple reason that, on his own showing, his diagnosis, prior to each injection, was less than perfunctory. It is true that, perhaps, he had used acetylarsan on many other estate workers, without any untoward results, but "neglect of duty does not cease by repetition to be neglect of duty:" *per* Lord Tomlin in *Bank of Montreal* v. *Dominion Gresham Guarantee & Casualty Co.*[4] Whether or not every care had been exercised in the diagnosis of earlier cases which he had similarly treated, the fact remains that there was proof of negligence in diagnosis in the case of this appellant.

I would therefore allow the appeal and give judgment in favour of the appellant.

It will now be necessary to deal with the question of damages. No special damage has been claimed. Fortunately for all parties the paralysis was not permanent. In the *Textbook* by *Price,* which I have quoted, it is stated that "the normal course of the disease is a stage of invasion followed by a stage of recession, leading to complete recovery. The duration of these varies according to the aetiology of the malady." In the event this statement has been fully borne out by the evidence. The appellant was unable to walk when discharged from the hospital. But, on his own admission, the paralysis lasted only some three months. He had since been able to walk. His main complaint, when he gave evidence in August 1960, was that he was "not in a position to resume normal work as conductor now." After careful consideration of all the circumstances I would assess damages at $7,500 and enter judgment for that sum with costs here and in the court below.

Appeal dismissed.

Solicitors: *H. W. Tan & George; Lovelace & Hastings; Shearn, Delamore & Co.*